PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY						
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	JG	00	COMPLETED		
		15G226	B. WING	,,,		01/08/	2013	
N. 1. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2.	DOLUDED OF STATE			TREET A	DDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIE	R	1503 WASHINGTON ST					
OCCAZI	O INC		N	IEW CA	ASTLE, IN 47362			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		1	ID PROVIDER'S PLAN OF CORI			(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TA	AG	DEFICIENCY)		DATE	
W0000								
	This visit was fo	or a fundamental annual	W0000)				
		nd state licensure survey.	110000					
	10001 tillication a	ina state incombane survey.						
	Dates of Survey	: December 10, 11, 12,						
	1	27, 2012, January 7, and 8,						
	2013.	,, <u></u> , , <u></u> , , , , , , , , , , , , , , , , , , ,						
	2013.							
	Provider Number	er: 15G226						
	Facility Number	r: 000750						
	AIM Number:							
	Surveyors:							
	Susan Eakright,	Medical Surveyor						
	III/QMRP/Team	-						
	-	N/BSN/Public Health						
	Nurse Surveyor							
	Traise surveyor							
	These federal de	eficiencies also reflect						
		accordance with 460 IAC						
	9.	decordance with 100 HTC						
	· ·							
	Quality review (completed January 15,						
		Walton, Medical Surveyor						
	III.	riation, ividaicai bui veyor						
	111.							

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000750

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA						(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED
		15G226	B. WIN			01/08/2013
NAME OF F	PROVIDER OR SUPPLIER			1503 W	ADDRESS, CITY, STATE, ZIP CODE VASHINGTON ST ASTLE, IN 47362	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE
W0125	The facility must of clients. Therefore and encourage in their rights as clie citizens of the Un right to file compliprocess. Based on observed record review for (clients #1, #2, # additional clients #8), the facility for the handsoap and further home. Findings included During the 12/10, between 4pm un home, clients #1, and #8's group for hallway was lock observed available bathrooms and keep home. At 4:10pm (DCS) #6 unlock gave client #2 had closet. At 5pm, locked closet to swater heater insistency of flushing their rights and history of flushing their rights and the close to swater heater insistency of flushing their rights as clients.	/12 observation period til 6:20pm at the group , #2, #3, #4, #5, #6, #7, ome closet on the back ked and no handsoap was alle for use in two of two itchen areas of the group m, Direct Care Staff ked the laundry room and andsoap from a locked DCS #6 unlocked the show the furnace and hot de the locked closet. At dicated client #5 had a ng handsoap down the	WO	125	W 125 Protection of Client Rights The facility must ensure the rigor all clients. Therefore, the facility must allow and encouraindividual clients to exercise the rights as clients of the facility to exercise their rights as clients the facility, and as citizens of the United States, including the right to file complaints, and the right due process. 1. What corrective action will be accomplished? Clients #1, #2, #3, #4, ##6, #7, and #8 will be put on programming to learn how to handle hazardous materials correctly. HRC approval will be obtained to have the hazardou materials and the furnace room locked until the Clients are ables show that they can use hazardous materials appropria	age neir o of he ght t to
	· ·	ng handsoap down the ad the staff gave out hand			hazardous materials appropria and access the furnace room	itely

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED		
		15G226	B. WING		01/08/2013
NAME OF I	PROVIDER OR SUPPLIE	R	1503 V	ADDRESS, CITY, STATE, ZIP CODE VASHINGTON ST CASTLE, IN 47362	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	soap for client use.			without concern.	
	(Qualified Development of the Color of the Side of the local ways kept local keys for the local ways kept local keys for the local ways kept local keys for the local ways kept local ways for the local local ways for the local local ways for the local local local ways for the local	5:35pm, the QDDP clopmental Disabilities ated "the closet was ked. Clients do not have and no one (clients #1, #6, #7, and #8) did not" ated reason for the elocked closet. At pDP indicated clients #1, #8 did not have an lable for review for the At 5:45pm, clients #1, #2, #7, and #8 indicated they are for the locked closets.		Clients #1, #2, #3, #4, 3 #6, #7 and #8 will be put on programming to understand the need for the furnace room and the dangers within the room. Clients #1, #2, #3, #4, 3 #6, #7 and #8 IPOP assessm will be updated to reflect their abilities to handle hazardous materials and the access the furnace room. Staff will be trained on Clients abilities to access the hazardous materials and the furnace room during their team meeting on 2-1-13.	the the
	and 12/6/12 ISP and 12/6/12 Bel did not indicate assessed in rega handsoap, furna closets. Client #2's recon 12/12/12 at 9:35 ISP did not indicate assessed in rega	rd was reviewed on 5 AM. Client #1's 12/7/11 (Individual Support Plan) navior Support Plan (BSP) client #1 had been rd to the need to lock ce, and the group home rd was reviewed on 5 AM. Client #2's 1/4/12 cate client #2 had been rd to the need to lock ce, and the group home		2. How will we identify of residents having the potentito be affected by the same deficient practice and what corrective action will be take. All residents have the potential to be affected by the same deficient practice. The IPOP assessments all of the residents will be reviewed and updated as their needs change. Staff will be trained on Clients abilities to access the hazardous materials and the furnace room during their teal.	en? s for the

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G226		A. BUILDING B. WING		COMPLETED 01/08/2013				
NAME OF P	ROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 1503 WASHINGTON ST					
OCCAZIO	O INC			CASTLE, IN 47362				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AF DEFICIENCY) meeting on 2-1-13	DULD BE COMPLET	ΓΙΟΝ		
				1.What measures will into place or what syst changes will be made ensure that the deficie practice does not recure. The IPOP assess all of the residents will be reviewed and updated a needs change. Staff will be trained Clients abilities to access hazardous materials an furnace room during the meeting on 2-1-13. 1.How will the correct action be monitored to the deficient practice werecur? The RC will monit regular basis daily when home. The Program Spemonitor as she complete audits.	temic to nt r? sments for be as their ed on the ss the d the eir team ctive ensure vill not tor on a n in the ecialist will es her			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED			
		15G226	A. BUILDING B. WING		01/08/2013		
NAME OF 3	PROVIDER OR SUPPLIE	ER	STREET ADDRESS, CITY, STATE, ZIP CODE 1503 WASHINGTON ST NEW CASTLE, IN 47362				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOU (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE COMPLETION		
	12/12/12 at 1 P indicated no ev the door to the the home. Client #4's reco 12/12/12 at 4 P indicated no ev the door to the the home. Interview with 11:25 AM, and indicated client #7, and #8's har were locked at QDDP indicate chemicals corrette agency had #2, #3, #4, #5, in the door to the the agency had #2, #3, #4, #5, in the door to the agency had #2, #3, #4, #5, in the door to the	ord was reviewed on M. The client's record idence for the need to lock furnace and handsoap in ord was reviewed on M. The client's record idence for the need to lock furnace and handsoap in the QDDP on 12/13/12 at on 12/14/12 at 10:35 AM, s #1, #2, #3, #4, #5, #6, adsoap and furnace closet the group home. The d clients do not use the ectly. The QDDP indicated not assessed clients #1, #6, #7, and #8 in regard to ap and the closets at the		February 7 th , 20	13		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPLI	ETED
		15G226	B. WIN			01/08/2013	
NAME OF D	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	ROVIDER OR SUFFLIER		1503 WASHINGTON ST				
OCCAZIO	O INC			NEW C	ASTLE, IN 47362		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
W0242	483.440(c)(6)(iii)	LSC IDENTIFTING INFORMATION)		TAU	BELIEBRELI		DATE
VVUZ4Z	INDIVIDUAL PRO	OGRAM PLAN					
		ogram plan must include,					
		vho lack them, training in					
		sential for privacy and					
	• •	cluding, but not limited to,					
		sonal hygiene, dental ding, bathing, dressing,					
		mmunication of basic					
		s been demonstrated that					
		opmentally incapable of					
	acquiring them.		1110	2.42			00/07/0010
	Based on record review and interview for 4 of 4 sample clients (#1, #2, #3 and #4),		W0	242	W 040 Individual Brancos Bla		02/07/2013
					W 242 Individual Program Pla	an l	
	· ·	I to ensure the clients'			The individual program plan m	ust	
	`	Support Plans) included			include, for those clients who I		
	the clients' identi	ified training objectives			them, training in personal skills	3	
	in regards to bath	ning, dressing and			essential for privacy and		
	toothbrushing.				independence (including, but r limited to, toilet training, perso		
					hygiene, dental hygiene,	iai	
	Findings include	¢			self-feeding, bathing, dressing	,	
					grooming, and communication		
	Client #1's record	d was reviewed on			basic needs), until it has been		
	12/12/12 at 8:45	AM. Client #1's 12/6/12			demonstrated that the client is developmentally incapable of		
	ISP (Individual S	Support Plan) indicated			acquiring them.		
	she required staf	f assistance with her					
	-	d no dressing objective.					
	Client #1's ISP d				1. What corrective action		
	toothbrushing ob	ojective. Client #1's 2012			will be accomplished?		
	_	l Comprehensive					
	,	ile) indicated she			· Programming will be		
		sistance to complete			implemented for Client #1 on		
	-	#1's 8/10/12 Dental			tooth brushing and dressing.		
	_	ated client #1 "required			Programming will be		
		" to complete dental			implemented for Client #2 on		
	, ,	ommended client #1 to			tooth brushing.		
			1				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED
		15G226	B. WIN			01/08/2013
					ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER		1503 WASHINGTON ST			
OCCAZIO	O INC		NEW CASTLE, IN 47362			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	brush teeth "thre	e times daily."			· Programming will be	
		•			implemented for Client #3 on	
	Client #2's recor	d was reviewed on			dressing, bathing, and tooth	
		AM. Client #2's			brushing.	
		assessment indicated			· Programming will be	
	client #2 "requir				implemented for Client #4 on	
	•				dressing, bathing, hair washin	g,
		dental cleaning. Client			and oral hygiene.	
	#2's 1/4/12 ISP o				The IOD's fee Oliver 114	
	toothbrushing ob	ojective.			The ISP's for Clients #1 #2, #3, #4 will be updated to	,
					include the above mentioned	
	Interview with the RC (Residential Coordinator) on 12/12/12 at 2 PM				objectives.	
	indicated client #	#1's ISP did not include				
	training objectiv	es to assist client #1 with				
	bathing, dressing	g, and oral hygiene. The			2. How will we identify oth residents having the potential	
	RC indicated cli	ent #2's ISP did not			to be affected by the same	"
	include a training	g objective to teach client			deficient practice and what	
	#2 oral hygiene.	5			corrective action will be take	n?
	, , , , , , , , , , , , , , , , , , , ,					
	Client #3's recor	d was reviewed on			All residents have the	
	12/12/12 at 1 PM	1. The client's ISP dated			potential to be affected by the same deficient practice.	
		d client #3 required staff			dame denoient practice.	
		nost of her self care tasks.			· The residents ISP's will	be
	Client #3's ICAF				reviewed and updated as their	
		Assessment Profile) of			needs change.	
	*	d client #3 "never or			As the residents needs	
					changed programming will be	
		ently dressed herself or			implemented.	
		Client #3's Updated				
	`	l Plan of Protective			· The residents behavior	
		3/27/12 indicated client			plans will be reviewed and updated as their needs change	
	_	ne verbal and some total			upuateu as their needs change	.
	assistance while	conducting personal				
	hygiene."					
	The IPPO indica	ted client #3 required			3. What measures will be	

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
		15G226	B. WIN	G		01/08/2013
NAME OF F	PROVIDER OR SUPPLIER			1503 W	ADDRESS, CITY, STATE, ZIP CODE 'ASHINGTON ST ASTLE, IN 47362	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	and wash her has choosing her clo choose weather a clothing may not indicated client and verbal promany training objectives." Client any training objectives	ical prompts" to bathe ir and "total assistance in thing" as "she will not appropriate clothing and a match." The IPPO #3 "requires supervision pts for all areas of oral #3's ISP did not indicate ectives to assist the client athing and oral hygiene.			put into place or what system changes will be made to ensure that the deficient practice does not recur: The residents ISP's will reviewed and updated as their needs change. As the residents needs changed programming will be implemented.	be r
	12/12/12 at 4 PM 9/13/12 indicated rarely" dressed ineatly, or washe Client #4's updat Information" of #4 "requires assist when bathing an completion." Cli General Information were to monitor 3 times a day. Client did not indicate in the state of the s	d was reviewed on I. The client's ICAP of d client #4 "never or derself completely and s and rinses her hair. The ded "IPPO - Residential 5/26/11 indicated client stance and monitoring d brushing teeth for task teent #4's updated "IPPO - tion" indicated the staff client #4's tooth brushing tient #4's ISP of 5/17/12 tany training objectives to with dressing, bathing, d oral hygiene.			The residents behavior plans will be reviewed and updated as their needs change. 4. How will the corrective action be monitored to ensure the deficient practice will not recur? The RC will monitor on daily basis when they are in the home. The Program Specialist monitor as they complete their audits.	re t a ane
	#10 on 12/11/12 #3 and #4 requir	OCS (Direct Care Staff) at 8 AM indicated clients ed assistance with g and oral hygiene.			5. What is the date by whi the systemic changes will be completed? February 7 th, 2013	
	Interview with the	ne RC (Residential				

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	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA I OF CORRECTION IDENTIFICATION NUMBER: 15G226	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMI 01/0	e survey Pleted 8/2013		
NAME OF	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 1503 WASHINGTON ST NEW CASTLE, IN 47362					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE		
	Coordinator) on 12/12/12 at 2 PM indicated client #3's and #4's ISPs did not include any training objectives to assist the clients with bathing, dressing and oral hygiene. 9-3-4(a)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			JRVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	A. BUILDING 00 COMPLETED			ΓED
		15G226	B. WIN			01/08/2	013
			D. WII		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	R			/ASHINGTON ST		
OCCAZIO) INC				ASTLE, IN 47362		
				7.0122, 114 47 002			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0249	483.440(d)(1)	ENACNITATION!					
	PROGRAM IMPL						
		nterdisciplinary team has nt's individual program plan,					
		receive a continuous active					
		m consisting of needed					
		services in sufficient					
		uency to support the					
		he objectives identified in					
	the individual pro	-					
	Based on observation, interview and record review for 4 of 4 sample clients (#1,		W0	249			02/07/2013
					W 249 Individual Program Pl	an	
					As soon as the interdisciplinary		
	#2, #3 and #4), a	and 1 additional client			As soon as the interdisciplinar team has formulated a client's		
		failed to ensure the DCS			individual program plan, each		
		ff) implemented the			client must receive a continuo		
	`	ividual Support Plan)			active treatment program		
	`	* *			consisting of needed interventions and services in		
		ves and provided formal					
		edication training when			sufficient number and frequen		
	opportunity exis	sted.			to support the achievement of the		
					objectives identified in the individual program plan.		
	Findings include	2:			individual program plan.		
	During observat	ions at the group home on					
	_	en 6:20 AM and 7:30 AM			1. What corrective action		
	the following wa				will be accomplished?		
	l life following wa	as observed.					
	1 DGG //10				Staff will be retrained on		
		observed preparing and			the importance of ensuring ac treatment at all times, especia		
		Grifulvin V Tab (an			during the med pass during th		
	_	ication), Zoloft (an			staff meeting on 2-1-13.		
	antidepressant),	Topiramate (an anti					
	seizure medicati	edication), Tri Sprintec (for			· A medication practicum	will	
	birth control) and 2 nasal sprays. DCS #10 did not offer client #1 any medication				be done with Staff #6 and #10 by 2-7-13.		
		iving client #1 her					
	medications.						
	medications.						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15G226		(X2) MU A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/08/2013	
NAME OF I	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 1503 WASHINGTON ST NEW CASTLE, IN 47362			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	giving client #2 dietary supplement depression), Neu Femara (used to #10 did not offer training while gi medications. 3. DCS #10 was giving client #3 problems), Levo Claritin (for alle dietary supplement decrease cholest offer client #3 an	observed preparing and Calcium Carbonate (a ent), Cymbalta (for arontin (for seizures) and treat breast cancer). DCS reclient #2 any medication ving client #2 her observed preparing and Asacol (for bowel nest (for birth control), regies), Nephro Cap (a ent) and Actigall (to erol). DCS #10 did not my medication training ent #3 her medications.			2. How will we identify oth residents having the potentiat to be affected by the same deficient practice and what corrective action will be take. All residents have the potential to be affected by the same deficient practice. Random medication practicums will be completed a staff to ensure that they are following the proper med pass procedures and providing opportunities for active treatm. Staff will be retrained on the importance of ensuring act treatment at all times, especial during the med pass during the staff meeting on 2-1-13.	en? with ent. n tive
	giving client #4 Lamictal (given Prilosec (for hea offer client	observed preparing and Calcium Carbonate, as a mood stabilizer) and rtburn). DCS #10 did not on training while giving dications.			3. What measures will be put into place or what syster changes will be made to ensure that the deficient practice does not recur: The residents ISP's will reviewed and updated as their needs change. Random medication practicums will be completed staff to ensure that they are following the proper med pass procedures and providing	be r with

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G226		A. BUILDING B. WING		COMPLETED 01/08/2013			
NAME OF P	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 1503 WASHINGTON ST NEW CASTLE, IN 47362				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				opportunities for active treatm Staff will be retrained or the importance of ensuring ac treatment at all times, especia during the med pass during th staff meeting on 2-1-13.	n tive Ily		
				4. How will the corrective action be monitored to ensure the deficient practice will not recur? The RC will monitor on daily basis when they are in the home. The Program Specialist monitor as they complete their	re t a ne will		
	_	ions at the group home on:10pm until 4:30pm, DCS		5. What is the date by whi the systemic changes will be completed? February 7 th , 2013			
	#6 completed me for clients #2, #4 DCS #6 dispense	edication administration I, and #6. At 4:10pm, ed client #2's oral irontin (for seizures) and					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
ANDILAN	OI CORRECTION	15G226		LDING	00	01/08/	
		100220	B. WIN			0 1/00/	2010
NAME OF F	ROVIDER OR SUPPLIER				ACHINGTON ST		
OCCAZIO	O INC				ASHINGTON ST ASTLE, IN 47362		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	` `	aviors) into a medication					
	cup, and gave the medications for client						
		OCS #6 did not offer					
	<u>-</u>	dication training while					
		her medications. At					
	• •	was dispensing client					
		Acetaminophen for					
		ter Shell Calcium for a					
	• •	ement into a medication					
	cup, and gave the medications for client						
	#4 to consume. Client #4 did not point at						
		DCS #6 did not offer					
	-	dication training while					
		her medications. At					
	4:25pm, Client #	6 dispensed with DCS#6					
	her medication (Gabapentin (Neurontin)					
	for seizures into	a medication cup, and					
	client #6 consum	ned the medication. DCS					
	#6 did not name	the medication, its reason					
	for use, or give r	nedication training					
	information to cl	ient #6 regarding the					
	Neurontin.						
	Client #1's recor	d was reviewed on					
	12/12/12 at 8:45	am. Client #1's 12/6/12					
	ISP (Individual S	Support Plan) indicated					
	,	dentify the reasons for her					
	Tylenol medicat						
	-						
	Client #2's recor	d was reviewed on					
	12/12/12 at 9:35	AM. Client #2's 1/4/12					
		objective to identify the					
	reasons for Tyle						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				00	COMPL		
		15G226	A. BUI B. WIN	LDING G		01/08/2013	
NAME OF I	PROVIDER OR SUPPLIER		D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
OCCAZIO			1503 WASHINGTON ST NEW CASTLE, IN 47362				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	Client #3's recor 12/12/12 at 1 PM (Individual Suppindicated client #4 to prepare items medication pass.) Client #4's recor 12/12/12 at 4 PM 5/17/12 indicated objective to poin medications in the Client #6's medications in the Client #6's (no month) objective to prepare medication administration with the Coordinator) on indicated the star formal and infor at every available indicated staff ac should follow the administration with the coordinator of the coordinated staff ac should follow the administration with the coordinated staff ac should follow the administration with the coordinated staff ac should follow the administration with the coordinated staff ac should follow the administration with the coordinated staff ac should follow the administration with the coordinate of	d was reviewed on f. Client #3's ISP fort Plan) of 3/29/12 #3 had a formal objective needed for her d was reviewed on f. Client #4's ISP of d client #4 had a formal at to her PM (evening) ne medication cart. cation record was 14/12 at 11am. Client 2012 ISP indicated an hare items for her nistration. ne RC (Residential 12/12/12 at 2 PM ff were to offer all clients mal medication training ne opportunity. The RC dministering medication which included naming of dosages, the reasons for					

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NAME OF PROVIDER OR SUPPLIER	DDRESS, CITY, STATE, ZIP CODE ASHINGTON ST STLE, IN 47362	COMPLETED 01/08/2013				
15G226 B. WING NAME OF PROVIDER OR SUPPLIER STREET ADI	SHINGTON ST	01/08/2013				
NAME OF PROVIDER OR SUPPLIER STREET ADI	SHINGTON ST					
NAME OF PROVIDER OR SUPPLIER	SHINGTON ST					
■ 1503 WAS						
	SILE, IN 47302					
OCCAZIO INC						
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID	PROVIDER'S PLAN OF CORRECTION	(X5)				
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION				
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	DEFICIENCY)	DATE				
W0290 483.450(b)(5) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Standing or as needed programs to control inappropriate behavior are not permitted. Based on record review and interview, for 3 of 4 sample clients (client #1, #3, and #4), the facility failed to prohibit the use of standing as needed orders for the use of physical restraints. Findings include: Client #1's record was reviewed on 12/12/12 at 8:45am. Client #1's 4/26/12 physician's orders indicated a standing order for "physical restraints." The physician's orders indicated the order for restraints had been in place since 2011. Client #1's 12/6/12 BSP (Behavior Support Plan) did not indicate the use of physical restraints.	W 290 Management of Inappropriate Client Behavior Standing or as needed programs to control inappropriate behavior are not permitted. 1. What corrective action will be accomplished? The standing order for restraints has been removed fr Client #1, #3, and #4's Medica Administration Record. Occazio's policy regarding Behavior Change Interventions Crisis will be reviewed will all standard their team meeting on 2-1-13. 2. How will we identify oth residents having the potentiate to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected by the same deficient practice.	02/07/2013 omtion ng s in taff er I				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G226		A. BUILDING B. WING		COMPLETED 01/08/2013			
NAME OF P	ROVIDER OR SUPPLIEF		STREET.				
OCCAZIO) INC		1503 WASHINGTON ST NEW CASTLE, IN 47362				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE		
		,		restraints has been removed all of the Client's Medication Administration Records wher restraint is not warranted in the behavior plan.	re		
				 Occazio's policy regard Behavior Change Intervention Crisis will be reviewed will all during their team meeting on 2-1-13. 	ns in staff		
				3. What measures will be			
				put into place or what syste changes will be made to ensure that the deficient practice does not recur:	emic		
				The residents ISP's wi reviewed and updated as the needs change.			
				The standing order for restraints has been removed all of the Client's Medication Administration Records wher restraint is not warranted in the behavior plan.	from e		
				Occazio's policy regar Behavior Change Interventio Crisis will be reviewed will all during their team meeting on 2-1-13.	ns in staff		
				4. How will the corrective	e		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G226		(X2) MUL A. BUILD B. WING		NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/08/2013			
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1503 WASHINGTON ST NEW CASTLE, IN 47362					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	(X5) COMPLETION DATE			
					action be monitored to ensur the deficient practice will not recur?	-		
					The RC will monitor on a daily basis when they are in th home.			
					The Program Specialist monitor as they complete their audits.			
					5. What is the date by which the systemic changes will be completed?			
					February 7 th , 2013			
	12/12/12 at 1 PM orders dated 3/20 indicated a stand restraints." The pindicated the ord in place since 3/record did not in behaviors or a B Plan). The client Report dated 7/1 #3 has had no renot on any psych	d was reviewed on 1. The client's physician's 2012 through 12/2012 ling order for "physical physician's orders ler for restraints had been 7/2011. The client's dicate any targeted SP (Behavior Support 's Behavior Clinician 9/2012 indicated client ported behaviors and is notropic medications. The client #3 did not need a						
	Client #4's recor	d was reviewed on						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G226			LDING	NSTRUCTION 00	(X3) DATE COMPL 01/08/	ETED		
NAME OF F	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1503 WASHINGTON ST NEW CASTLE, IN 47362					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	orders dated 3/20 indicated a stand restraints." The prindicated the ordin place since 3/of 5/17/12 did not physical restrain. Interview with E #10 on 12/11/12 clients living in a physical restrain. Interview with the Coordinator on indicated clients standing orders a called "Handle when the clients restrained. The F #3, and #4 had not restraint. The RC	at 7:30 AM indicated no the group home required ts due to behaviors. The RC (Residential 12/12/12 at 4:30 PM #1, #3, and #4 had for a physical restraint with Care" to use if and might need to be RC indicated clients #1, to history for the need of C stated the order was in the the staff would have to						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G226		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/08/2013		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1503 WASHINGTON ST NEW CASTLE, IN 47362				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR TAG DEFICIENCY)		TE	(X5) COMPLETION DATE
W0369	assure that all dra are self-administed without error. Based on observe interview for 2 or observed being a failed to ensure a administered with administered with the self-administered with the self-administere	aug administration must ugs, including those that ugs, including those that ered, are administered ation, record review and f 43 medications dministered, the facility all medications were hout error to client #4. : on at the group home on pm, DCS (Direct Care stered client #4's a medication blister indicated "ASA") 325mg (milligrams) rs)" for Arthritis. At this 12/2012 MAR ininistration Record) was licated "ASA") 325mg every 6 hrs." ons at the group home on in 5:45 AM and 7:50 AM,	W0	369	W 369 Drug Administration The system for drug administration must assure that all drugs, including those that self-administered, are administered without error. 1. What corrective action will be accomplished? Staff will be retrained or the medication administration pass procedures and the importance of following the physicians orders during their staff meeting on 2-1-13. A medication practicum be done with Staff #6 and #10 2-7-13. Client #4's ASA medical order will be reviewed by the nurse. The MAR and medicatil label will be updated to ensure that it matches the physician's order. Client #4's Prilosec will retimed to allow it to be given before she eats breakfast.	will by	02/07/2013

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			COMPLETED
		15G226	B. WING 01/08/2013			01/08/2013
			B. WIN		ADDRESS SITY STATE TIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE	
000471	0.11.0				ASHINGTON ST	
OCCAZIO	3 INC			NEW C	CASTLE, IN 47362	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	- Client #4 was t	to be given Prilosec 20				
		re food or a meal but not				
	before 7:30 AM.				2. How will we identify oth	ner
					residents having the potential	al
	- Client #4 was to be given ASA (Aspirin) 650 milligrams every 8 hours.				to be affected by the same	
					deficient practice and what	
					corrective action will be take	n?
	Review of client	#4's MAR (Medication				
		Record) for December			· All residents have the	
2012 at 7:35 AM indicated:				potential to be affected by the		
	- Client #4 was to be given Prilosec				same deficient practice.	
		•			· Random medication	
	before food or a meal but not before 7:30 AM.				practicums will be completed	with
					staff to ensure that they are	
	- Client #4 was t	to get ASA 650			following the proper med pass	
	milligrams every	6 hours for Arthritis.			procedures and the prescribed	
					doctor's orders.	
	Interview with F	OCS (Direct Care Staff)				
		,			Staff will be retrained or	۱
		at 7:40 AM indicated she			the medication administration	
		the special instructions on			pass procedures and the	
	the MAR or on t	the pill pack for client #4			importance of following the physicians orders during their	
	to be given her I	Prilosec before food or a			staff meeting on 2-1-13.	
	meal but not bef	ore 7:30 AM. DCS #10			Stair Moeting on 2 1 10.	
		outinely eats her			· The MAR's and medica	tion
		6 AM and the Prilosec			labels will be reviewed by the	
					to ensure that the physician	
	1	en given after the client			orders are being followed and	
		DCS #10 stated the			everything matches.	
		ve been notified of the				
	discrepancy, but	"Apparently no one				
	caught it."				2 What mass	
	Interview with the facility nurse on 12/13/12 at 9:30 AM indicated all medications were to be given as the				3. What measures will be	nic
					put into place or what syster changes will be made to	
					ensure that the deficient	
					practice does not recur:	
					practice does not recur.	
	physician had pr	rescribed and as directed			Random medication	
	on the MAR. The facility nurse indicated				practicums will be completed	with

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	of Correction identification number: 15G226	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMPLETED 01/08/2013		
NAME OF 1	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 1503 WASHINGTON ST NEW CASTLE, IN 47362				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	the DCS were to triple check the medication with the physician's orders, the MAR and the pill pack to ensure all three match. The facility nurse indicated the DCS should have notified nursing of the discrepancy of not giving client #4 the Prilosec until 7:30 AM but prior to eating, and of the discrepancy in client #4's order for the ASA. Client #4's ASA physician's order indicated the medication was, to be taken every 6 hours. 9-3-6(a)		staff to ensure that they are following the proper med pass procedures and the prescribe doctor's orders. Staff will be retrained of the medication administration pass procedures and the importance of following the physicians orders during their staff meeting on 2-1-13. The MAR's and medical labels will be reviewed by the to ensure that the physician orders are being followed and everything matches. 4. How will the corrective action be monitored to ensure the deficient practice will not recur? The RC will monitor on daily basis when they are in the home. The Program Specialist monitor as they complete their audits. 5. What is the date by what the systemic changes will be completed? February 7 th, 2013	re t a ne twill r		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G226		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/08/2013		
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1503 WASHINGTON ST NEW CASTLE, IN 47362				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APP DEFICIENCY)		TE	(X5) COMPLETION DATE
W0426	where clients who regulate water ten hot water, ensure water does not expanded. Based on observinterview the fact water temperature degrees Fahrenhot clients (client #1	in areas of the facility have not been trained to imperature are exposed to that the temperature of the sceed 110 degrees ation, record review and fility failed to ensure res did not exceed 110 eit for 4 of 4 sampled fig. #3 and #4), and 4 fig. (client #5, #6, #7 and for adjust water	WO	426	W 426 Client Bathrooms The facility must, in areas of the facility where clients who have been trained to regulate the water are exposed to he water, ensure that the temperature of the water does exceed 110 degrees Fahrenhe	e not ater ot anot	02/07/2013
	clients #1, #2, #3 were observed at the observation p observed to inde the water in the l laundry room. During observati 12/11/12 betwee the water was ob keep this surveye hand washing. S from the sink. Th taken on 12/11/1	m 4pm until 6:20pm, 8, #4, #5, #6, #7, and #8 the group home. During period clients were pendently turn on and off kitchen, bathrooms, and ons at the group home on n 5:45 AM and 8 AM, served to be too hot to per's hands in it for routine team was observed rising ne water temperature was 2 at 7:50 AM in the main group home and was			1. What corrective action will be accomplished? The water temperature the home has been adjusted be to 110 degrees Fahrenheit. Staff is to complete wate temperature checks three times week and document the findin on the water temperature checks heet in Therap. Temperature above 110 degrees Fahrenhei are reported to the RC for the home. Staff will be retrained or the importance of checking the water temperature and reporting temperature concerns to the Faduring their team meeting on	er es a gs ck s it	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETI			ETED	
		15G226	B. WING 01/08/2013			2013	
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹	1503 WASHINGTON ST				
OCCAZIO) INC		NEW CASTLE, IN 47362				
					AGTEE, IN 47 302		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
	found to be 120	degrees Fahrenheit.			2-1-13.		
					· Water temperature		
	Client #1's recor	d was reviewed on			assessments will be complete	d	
	12/12/12 at 8:45am. Client #1's record				with Client #1, #2, #3, #4, #5,		
	did not indicate	client #1 could adjust the			#7, and #8.		
		re at the group home.					
	water temperatus	se at the group name.			The IPOP assessments		
	Client #2's recor	d was reviewed on			be updated to reflect Client's #		
					#2, #3, #4, #5, #6, #7, and #8'	S	
	12/12/12 at 9:35am. Client #2's record did not indicate client #2 could adjust the water temperature at the group home.				abilities to regulate water temperatures.		
					l tomporataros.		
	Client #3's recor	d was reviewed on			2. How will we identify oth		
	12/12/12 at 1 PN	A. The client's record did			residents having the potentia	al	
	not indicate clien	nt #3 could adjust the			to be affected by the same		
	water temperatu	re within the group home.			deficient practice and what corrective action will be take	n 2	
	•	.			Corrective action will be take	11:	
	Client #4's recor	d was reviewed on			· All residents have the		
		1. The client's record did			potential to be affected by the		
		nt #4 could adjust the			same deficient practice.		
		re within the group home.			Ot-# :- t		
	water temperatu	ie within the group home.			 Staff is to complete wat temperature checks three time 		
	Intomican anida	OCS (Direct Core Staff)			week and document the finding		
		OCS (Direct Care Staff)			on the water temperature chec	•	
		(Residential Coordinator)			sheet in Therap. Temperature	S	
		AM indicated the water			above 110 degrees Fahrenhei	it	
	1 .	ne was not supposed to be			are reported to the RC for the		
	above 110 degre	es Fahrenheit. The RC			home.		
	indicated she wo	ould have to call someone			Staff will be retrained or	า	
	to look at the wa	iter heater.			the importance of checking the		
					water temperature and reporti		
	Interview with the	he RC on 12/12/12 at			temperature concerns to the F		
	11am, indicated no documentation and no				during their team meeting on		
	· ·	re available for review to			2-1-13.		
					The IPOP assessments		
	determine ii che	nts #1, #2, #3, #4, #5, #6,			ine inor assessments	•	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU	LTIPLE CO	ONSTRUCTION	(X3) DATE S COMPLE		
ANDILAN	or connection	15G226	A. BUIL		00	01/08/2	
		100220	B. WINC		A PARAGO CITAL CTATE TIA CORE	01/00/2	-010
NAME OF P	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE ASHINGTON ST		
OCCAZIO	O INC				ASTLE, IN 47362		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	'	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710		capable of mixing hot		1710	and water temperature	-	DITTE
	-	emperature when it			assessments will be reviewed and updated as the resident's	I	
		grees Fahrenheit.					
		8			needs change.		
	9-3-7(a)	7(a)					
					3. What measures will be		
					put into place or what systen	nic	
					changes will be made to ensure that the deficient		
					practice does not recur:		
						0.5	
					 Staff is to complete wat temperature checks three time 		
					week and document the findin		
					on the water temperature chec		
					sheet in Therap. Temperature above 110 degrees Fahrenhei		
					are reported to the RC for the		
					home.		
					· Staff will be retrained or	n	
					the importance of checking the		
					water temperature and reporti temperature concerns to the F		
					during their team meeting on		
					2-1-13.		
					· The IPOP assessments	,	
					and water temperature		
					assessments will be reviewed		
					and updated as the resident's needs change.		
					4. How will the corrective		
					action be monitored to ensure the deficient practice will not recur?		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15C226		A. BUILDING 00 COMPLETED 01/08/2013						
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
OCCAZIO INC			1503 WASHINGTON ST NEW CASTLE, IN 47362					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)				
				 The RC will monitor on daily basis when they are in th home. 				
				The Program Specialist monitor as they complete their audits.				
				The Maintenance Direct will also monitor as he comple his checks.				
				5. What is the date by whi the systemic changes will be completed?				
				February 7 th , 2013				

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Event ID: LJSW11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION . DUMBRIS 00			(X3) DATE SURVEY COMPLETED	
15G226		A. BUILDING			01/08/2013	
		100220	B. WIN		ADDRESS SITY STATE ZID CODE	01/00/2010
NAME OF	PROVIDER OR SUPPLIE	₹			ADDRESS, CITY, STATE, ZIP CODE VASHINGTON ST	
OCCAZI	O INC				CASTLE, IN 47362	
(X4) ID	SUMMARY S	SUMMARY STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORE		(X5)
PREFIX	``	ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE
W0440	483.470(i)(1) EVACUATION D	DILLE				
		hold evacuation drills at				
		r each shift of personnel.				
	Based on record review and interview, the		W0440			02/07/2013
		r 4 of 4 sampled clients			W 440 Evacuation Drills	
	_	44), and 4 additional				
	. , ,	\$7 and \$8) who resided in			The facility must hold evacuat	
	, , ,	to ensure evacuation			drills at least quarterly for each shift of personnel.	n
		ucted at least quarterly for			Stillt of personner.	
		AM - 3 PM) for the first				
	` `	· · · · · · · · · · · · · · · · · · ·				
	quarter (January, February and March)				1. What corrective action	
	· ·	quarter (April, May and			will be accomplished?	
	,	nd for the night shift (11			A day shift (7am-3pm) a	and
	· · · · · · · · · · · · · · · · · · ·	the third quarter (July,			night shift (11pm-7am) drill wil	
	August and Sept	tember) of 2012.			run by 2-7-13.	
	Findings include	: :			· The importance of ensu	
					that evacuation drills are ran a	
	The facility's eva	acuation drills were			least quarterly for each shift o personnel will be reviewed wit	
	reviewed on 12/	10/12 at 3 PM. The			the staff and RC during their to	
	review indicated	I the facility had failed to			meeting on 2-1-13.	
		ion drills for clients #1,				
		6, #7 and #8 for the first			A drill tracking sheet wi	
	and the second quarters of 2012 for the				utilized by the RC and DSA to ensure that drills for each shift	
		the third quarter of 2012			personnel are being conducte	
	for the night shift	-			personnia are boning conducte	~.
	Tot the mant sin	· v.				
	Interview with the PS (Program Specialist) on 12/12/12 at 1 PM indicated she was unable to locate any further evacuation drills for clients #1, #2, #3, #4,				2 Hour will was intended and	
					2. How will we identify oth residents having the potential	
					to be affected by the same	ai e
					deficient practice and what	
					corrective action will be take	n?
	#5,	with a first and the account				
	-	or the first and the second			All residents have the	
	quarters of 2012	for the day shift and for	1		potential to be affected by the	

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AND PLAN OF CORRECTION IDE		IDENTIFICATION NUMBER: 15G226	A. BUII	LDING	00	COMPL	COMPLETED 01/08/2013	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER OCCAZIO INC			1503 WASHINGTON ST NEW CASTLE, IN 47362					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
	the third quarter shift. 9-3-7(a)	of 2012 for the night			same deficient practice. The importance of ensu that evacuation drills are ran a least quarterly for each shift of personnel will be reviewed with the staff and RC during their to meeting on 2-1-13. A drill tracking sheet will utilized by the RC and DSA to ensure that drills for each shift personnel are being conducted.	t n eam I be		
					3. What measures will be put into place or what system changes will be made to ensure that the deficient practice does not recur: The importance of ensurement that evacuation drills are ran a least quarterly for each shift of personnel will be reviewed with the staff and RC during their termeeting on 2-1-13. A drill tracking sheet will utilized by the RC and DSA to ensure that drills for each shift personnel are being conducted. 4. How will the corrective action be monitored to ensure the deficient practice will not recur? The RC will monitor on a	ring t n eam l be of d.		

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	OF CORRECTION	IDENTIFICATION NUMBER: 15G226	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMPLETED 01/08/2013
NAME OF P	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP CODE VASHINGTON ST	
OCCAZIO INC				CASTLE, IN 47362	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
				daily basis when they are in home.	n the
				The Program Special monitor as they complete the audits.	
				5. What is the date by withe systemic changes will completed?	
				February 7 th , 2013	

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OF CORRECTION	4					
OF CORRECTION	IDENTIFICATION NUMBER:	A BIIII	A. BUILDING COMPLET			ETED
	15G226				01/08/2013	
		D. (12.)		ADDRESS, CITY, STATE, ZIP CODE		
PROVIDER OR SUPPLIER						
OCCAZIO INC			NEW CASTLE, IN 47362			
(EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ΓE	COMPLETION
REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
Each client must well-balanced die specially-prescrib Based on observation for the special spe	receive a nourishing, t including modified and ed diets. ation, interview and r 4 of 4 sampled clients 44), and 4 additional 7 and #8), the facility he DCS (Direct Care he facility menu to ensure	WO	460			02/07/2013
During observation 12/11/12 between clients #1, #2, #3 were observed ear clients proposed earlier the clients proposed earlier than cottage cheen the facility Fall/10/7/09 were revisited earlier	sons at the group home on in 5:45 AM and 6:30 AM, is, #4, #5, #6, #7 and #8 atting their breakfast. The erved eating cereal (cold milk and juice. The clients at butter or cottage act Care Staff did not peanut butter or cottage attute for the peanut butter see that was on the menu. Winter menus dated riewed on 12/11/12 at at led Regular Adult ents were to have 3/4 cup 63/4 cup of whole grain			will be completed by the RC and/or the DSA for the home to ensure that the menu is being followed and that staff are encouraging the residents to follow their prescribed dining plans. Staff will be retrained or Client #1, #2, #3, #4, #5, #6, # and #8's dining plans, how to provide appropriate food substitutions and the important of following the menu at their statement on 2-1-13. How will we identify other residents having the potentiat to be affected by the same deficient practice and what	o 7 ce staff	
	SUMMARY ST (EACH DEFICIENCE REGULATORY OR 483.480(a)(1) FOOD AND NUTI Each client must in well-balanced dieses specially-prescribes and on observation of the clients (#5, #6, #6 failed to ensure the staff) followed the clients receives Findings includes During observation observation of the clients receives for the clients were observed each of the clients proffer the clients	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, interview and record review for 4 of 4 sampled clients (#1, #2, #3 and #4), and 4 additional clients (#5, #6, #7 and #8), the facility failed to ensure the DCS (Direct Care Staff) followed the facility menu to ensure the clients received a nutritious meal. Findings include: During observations at the group home on 12/11/12 between 5:45 AM and 6:30 AM, clients #1, #2, #3, #4, #5, #6, #7 and #8 were observed eating their breakfast. The clients were observed eating cereal (cold and hot), toast, milk and juice. The clients did not eat peanut butter or cottage cheese. The Direct Care Staff did not offer the clients peanut butter or cottage cheese or a substitute for the peanut butter and cottage cheese that was on the menu. The facility Fall/Winter menus dated 10/7/09 were reviewed on 12/11/12 at	ROVIDER OR SUPPLIER DINC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, interview and record review for 4 of 4 sampled clients (#1, #2, #3 and #4), and 4 additional clients (#5, #6, #7 and #8), the facility failed to ensure the DCS (Direct Care Staff) followed the facility menu to ensure the clients received a nutritious meal. Findings include: During observations at the group home on 12/11/12 between 5:45 AM and 6:30 AM, clients #1, #2, #3, #4, #5, #6, #7 and #8 were observed eating their breakfast. The clients were observed eating cereal (cold and hot), toast, milk and juice. The clients did not eat peanut butter or cottage cheese. The Direct Care Staff did not offer the clients peanut butter or cottage cheese or a substitute for the peanut butter and cottage cheese that was on the menu. The facility Fall/Winter menus dated 10/7/09 were reviewed on 12/11/12 at 6:15 AM. The menu labeled Regular Adult indicated the clients were to have 3/4 cup of orange juice, 3/4 cup of whole grain cereal cooked or dry, 2 slices of whole	ROVIDER OR SUPPLIER D INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, interview and record review for 4 of 4 sampled clients (#1, #2, #3 and #4), and 4 additional clients (#5, #6, #7 and #8), the facility failed to ensure the DCS (Direct Care Staff) followed the facility menu to ensure the clients received a nutritious meal. Findings include: During observations at the group home on 12/11/12 between 5:45 AM and 6:30 AM, clients #1, #2, #3, #4, #5, #6, #7 and #8 were observed eating their breakfast. The clients were observed eating cereal (cold and hot), toast, milk and juice. The clients did not eat peanut butter or cottage cheese. The Direct Care Staff did not offer the clients peanut butter or cottage cheese or a substitute for the peanut butter and cottage cheese that was on the menu. The facility Fall/Winter menus dated 10/7/09 were reviewed on 12/11/12 at 6:15 AM. The menu labeled Regular Adult indicated the clients were to have 3/4 cup of orange juice, 3/4 cup of whole grain cereal cooked or dry, 2 slices of whole	ROVIDER OR SUPPLIER DINC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR I.S. (IDENTIFYING INFORMATION) 483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, interview and record review for 4 of 4 sampled clients (#1, #2, #3 and #4), and 4 additional clients (#5, #6, #7 and #8), the facility failed to ensure the DCS (Direct Care Staff) followed the facility menu to ensure the clients received a nutritious meal. Findings include: 1. What corrective additional clients (#1, #2, #3, #4, #5, #6, #7 and #8 were observed eating their breakfast. The clients were observed eating their breakfast. The clients were observed eating their breakfast. The clients were observed eating coreal (cold and hot), toast, milk and juice. The clients did not eat peanut butter or cottage cheese. The Direct Care Staff did not offer the clients peanut butter or cottage cheese or a substitute for the peanut butter and cottage cheese that was on the menu. The facility Fall/Winter menus dated 10/7/09 were reviewed on 12/11/12 at 6:15 AM. —The menu labeled Regular Adult indicated the clients were to have 3/4 cup of orange juice, 3/4 cup of whole grain cereal cooked or dry, 2 slices of whole	ROVIDER OR SUPPLIER D INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FILL REGULATORY OR LSC IDENTIFYING INFORMATION) 483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially prescribed diets. Based on observation, interview and record review for 4 of 4 sampled clients (#1, #2, #3 and #4), and 4 additional clients (#5, #6, #7 and #8), the facility failed to ensure the DCS (Direct Care Staff) followed the facility menu to ensure the clients received a nutritious meal. Findings include: 1. What corrective action will be accomplished? Regular meal observations

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) N	IULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	ILDING	00	COMPLETED		
		15G226	B. WIN			01/08/2013		
NAME OF I	DROVIDED OD CLIDDLIED		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER				1503 W	ASHINGTON ST			
OCCAZIO INC				NEW CASTLE, IN 47362				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION FACE CORRECTIVE ACTION SHOULD BE		(X5)		
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)				
TAG		LSC IDENTIFYING INFORMATION)		TAG	potential to be affected by the	DATE		
	-	sugar jelly, 2 tablespoons			same deficient practice.			
	_	and 1 cup of skim or			James demonernt praduces			
	1/2% milk.				· Regular meal observati	ons		
		led Low Fat, Low			will be completed by the RC			
	· · · · · · · · · · · · · · · · · · ·	Concentrated Sweets			and/or the DSA for the home t ensure that the menu is being			
		ents were to have 3/4 cup			followed and that staff are			
		3/4 cup of whole grain			encouraging the residents to			
		dry, 2 slices of whole			follow their prescribed dining			
	· ·	aspoon of margarine, 1			plans.			
	teaspoon of low	sugar jelly, 2 tablespoons			Staff will be retrained or	,		
	of peanut butter	and 1 cup of skim or	Client #1, #2, #3, #4, #5, #6, #7					
	1/2% milk.				and #8's dining plans, how to			
	The menu labe	led 1800 Kcal (calories)			provide appropriate food			
	indicated the clie	ents were to have 1/2 cup			substitutions and the importan			
	of orange juice,	3/4 cup of whole grain			of following the menu at their meeting on 2-1-13.	Statt		
	cereal cooked or	dry, 1/2 slice of whole			I meeting on 2-1-10.			
	wheat toast, 1 tea	aspoon of margarine, 1						
	· ·	sugar jelly, 1 tablespoon						
	_	and 1 cup of skim or			3. What measures will be			
	1/2% milk.	•			put into place or what syster changes will be made to	nic		
	The menu labe	led 1500 Kcal (calories)			ensure that the deficient			
		ents were to have 1/2 cup			practice does not recur:			
		3/4 cup of whole grain						
		dry, 1/2 slice of whole			Regular meal observation	ons		
		aspoon of margarine, 1			will be completed by the RC and/or the DSA for the home t			
		sugar jelly, 1 tablespoon			ensure that the menu is being			
	_	and 1 cup of skim or			followed and that staff are			
	1/2% milk.	and I cup of skill of			encouraging the residents to			
	The menu labeled Mechanical Soft indicated the clients were to have 3/4 cup				follow their prescribed dining			
					plans.			
					Staff will be retrained or	,		
		1 and 1/2 cup of whole			Client #1, #2, #3, #4, #5, #6, #			
	~	ked or soaked until soft, 1			and #8's dining plans, how to			
		heat toast moistened and			provide appropriate food			
	cut into 1/4 to 1/	2 inch pieces, 1 teaspoon			substitutions and the importan	ice		

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STATEMENT OF DEFICIENCIES X1) PROV		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED		
		15G226	B. WIN			01/08/2013		
			D. (12)		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER				1503 WASHINGTON ST				
OCCAZIO INC				NEW CASTLE, IN 47362				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	,	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION		
TAG		LSC IDENTIFYING INFORMATION)		TAG	•	DATE		
	of margarine, 1 teaspoon of low sugar jelly, 1/4 cup of low fat cottage cheese				of following the menu at their smeeting on 2-1-13.	stati		
					incetting on 2-1-13.			
	and 1 cup of skir	m or 1/2% milk.						
		OCS #10 on 12/11/12 at 8			4. How will the corrective			
	AM indicated th	e menus previously			action be monitored to ensur			
	reviewed were the	he menus the staff were to			the deficient practice will not recur?	•		
	follow in preparing clients #1, #2, #3, #4,							
	#5, #6, #7 and #	8's meals. DCS #10			· The RC will monitor on	a		
	indicated the sta	ff were to follow the			daily basis when they are in th	e		
	facility menus as	nd to offer all of the food			home.			
	on the menu. DO	CS #10 stated, "That's my			· The Program Specialist	will		
	fault, I didn't offer the peanut butter. We have a couple of ladies that have choking				monitor as they complete their			
					audits.			
	•	thought it wouldn't be a						
	good idea for them to have peanut butter."							
		ted she should have			5. What is the date by whi	ch		
					the systemic changes will be			
	offered the clients a substitute protein, but she had not thought about it at the time breakfast was being prepared.				completed?			
	bicakiasi was be	ang prepared.			February 7 th , 2013			
	Interview with the	he RC (Residential						
		12/12/12 at 2 PM						
	'	CS were to offer all of the						
		nu or to provide a like						
		e food not offered.						
	Succession for the							
	9-3-8(a)							
) 5 0(u)							

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